

NOTICE OF INDEPENDENT REVIEW DECISION

February 26, 2003

RE: MDR Tracking #: M2-03-0562-01
IRO Certificate #: IRO 4326

The ____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 46 year old male sustained a work-related injury on ____ when he was cleaning the floor and fell on a sink hitting his back. The patient underwent an MRI of the lumbar spine on 05/03/01 and electro-diagnostic studies on 06/28/01. The patient has been diagnosed with lumbar degenerative joint disease with radiculitis and has been treated with lumbar epidural steroid injections. The treating physician has recommended that the patient undergo a lumbar discogram and has also recommended the purchase of a muscle stimulator.

Requested Service(s)

Lumbar discogram and the purchase of a muscle stimulator

Decision

It is determined that the lumbar discogram is not medically necessary to treat this patient's condition. However, it is determined that the purchase of a muscle stimulator is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The radiologist's report of the lumbar MRI dated 05/03/01 states that the patient has multi-level spinal disc degeneration at levels L3-4, L4-5, and L5-S1. Neither surgery in form of a spinal fusion nor Intradiscal Electrothermal therapy (IDET) would be appropriate for the treatment of 3 level disc degeneration. Therefore, provocative discography is not indicated.

The patient did have a trial of a muscle stimulator and medical record documentation indicates that the patient had a decreased use of medication and increased function due to reduction in pain with the use of the stimulator. Therefore, continued use of a muscle stimulator is medically indicated.

Therefore, it is determined that the lumbar discogram is not medically necessary; however, the purchase of a muscle stimulator is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26 th day of February 2003.
